SECTION 1915(c) WAIVER FORMAT

1. The State of **Alabama** requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a._____ Yes b.__**X**__ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a._____ 3 years (initial waiver)

   b.__**X**__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a._____ Nursing facility (NF)

   b.__**X**__ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c._____ Hospital

   d._____ NF (served in hospital)

   e._____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. _____ aged (age 65 and older)

b. _____ disabled

c. _____ aged and disabled

d. **X** mentally retarded

e. _____ developmentally disabled

f. _____ mentally retarded and developmentally disabled

g. _____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. **X** Waiver services are limited to the following age groups (specify):
Three years of age and above.

b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs,but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. _____ Other criteria. (Specify):

e._____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a._____ Yes b.__**X**__ No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a._____ Yes b.__**X**__ No c._____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a._____ Yes b.__**X**__ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a._____ Yes b.__**X**__ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

a. **X** Yes b. _____ No

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. _____ Case management

b. _____ Homemaker

c. _____ Home health aide services

d. **X** Personal care services

e. **X** Respite care

f. _____ Adult day health

g. **X** Habilitation

X Residential habilitation

X Day habilitation

X Prevocational services

X Supported employment services

_____ Educational services

h. **X** Environmental accessibility adaptations

i. **X** Skilled nursing

j. _____ Transportation

k. **X** Specialized medical equipment and supplies

l._____ Chore services

m._____ Personal Emergency Response Systems

n. X Companion services

o._____ Private duty nursing

p._____ Family training

q._____ Attendant care

r._____ Adult Residential Care

_____ Adult foster care

_____ Assisted living

s._____ Extended State plan services (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

_____ Prescribed drugs

_____ Other (specify):

t. **X** Other services (specify):

Assistive Technology
Physical Therapy
Occupational Therapy
Speech and Language Therapy
Behavior Therapy
Community Specialist
Crisis Intervention

u._____ The following services will be

provided to individuals with chronic mental illness:

_____ Day treatment/Partial hospitalization

_____ Psychosocial rehabilitation

_____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. **X** When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. _____ Meals furnished as part of a

program of adult day health services.

c._____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this

request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. **X** Yes b. _____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. _____ Yes b. **X** No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of October 1,2004 is requested.

19. The State contact person for this request is **Janice Peterson**, who can be reached by telephone at **(334)242 5653**.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under

its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: **Carol H. Steckel**

Title: **Commissioner, Alabama Dept. of Medicaid**

Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

X The waiver will be operated by the **Department of Mental Health and Mental Retardation**, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

_____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. No **Case Management**

b. No **Homemaker:**

c. No **Home Health Aide Services:**

d. Yes **Personal Care Services**:

X Other service definition (Specify):

Definition

Personal Care Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

Personal Care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate code for this service, provided at the worksite, to distinguish it from other personal care activities, effective in Fiscal Year 2007.

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported. The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer. This service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation

by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

Personal care under the waiver may also include general supervision and protective oversight reasonable to accomplishing of health, safety and inclusion. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual. A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Mental Retardation and be subject to review by the Single State Agency for Medicaid.

While in general personal care will not be approved for a person living in a group home or other residential setting, the Division of Mental Retardation may approve it for specific purposes that are not duplicative.

The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Parents and other caretakers shall be key informers on the matter of special training, and will be encouraged to participate in the training and supervision of the worker.

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's documented need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

Place of Service / Unit of Service

There is no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Payment is for a 15 minute unit of service, not including worker's time of travel to and from the place of work.

Provider Qualifications

Provider qualifications are specified in Appendix B-2.

Relatives as Providers

Personal Care Workers shall not be members of the immediate family (parents, spouses children or siblings) of the person

being supported, nor may they be legally obligated in any other way to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

Relation to State Plan Services

Personal Care Services under the State Plan differ in service definition from the services to be offered under the waiver.

e. Yes **Respite care:**

X Other service definition (Specify):

Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member.

Respite is intended for participants whose primary caregivers typically are the same persons day after day (e.g. family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation. As crisis relief, out of home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in his home, or if necessary, to locate another home for him.

Some consumers are institutionalized because their community supports become exhausted, or because they don't know how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without additional intervention and supports. Planning will be made for alternate residential supports if return is not possible. The goal is to avoid institutionalization. Respite care is highly cost effective as an alternative to long term placement in an ICF/MR.

Respite care is dependent on the individual's needs as set forth in the plan of care and requires approval by the Division of Mental Retardation, subject to review by the Alabama Medicaid Agency. The limitation on either in home or out of home Respite Care shall be 1080 hours or 45 days per waiver participant per waiver year.

Respite care out of the home may be provided in a certified

group home or ICF/MR. In addition, if the recipient is less than 21 years of age, respite care out of the home may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out of home respite, no additional Medicaid reimbursement will be made for other services in the institution. The requirements for the agency and personnel providing the respite are contained in appendix B-2-a.

FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

f. No **Adult day health:**

g. Yes **Habilitation:**

X **Other service definitions follow for Residential Habilitation, Day Habilitation, Prevocational Employment and Supported Employment:**

Residential Habilitation

Residential habilitation services provide care, supervision, and skills training in activities of daily living, home management and community integration. Residential habilitation services may be provided either in the waiver recipient's residence (family home, own home or apartment) or in a certified community setting. All settings that are so required must have appropriate site and programmatic certification from the Administering Agency.

Residential habilitation activities must relate to identified, planned goals. Training and supervision of staff by a QMRP shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements are specified in Appendix B-2; these must be met prior to the staff beginning work. For recipients living in certified residences, staff must be trained regarding the individual recipient's plan of care prior to beginning work with the recipient. For recipients living independently or with family, additional training to specifically address and further the goals in the individual's plan may occur on the job. In these settings, consumers and family members shall be included in the planning, and shall be offered and encouraged to use the opportunity to participate in the training and supervision of the staff.

The service includes the following:

- Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist

of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment. This may mean changing factors that impede progress (i.e. moving a chair, substituting velcro closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.

- Habilitation supplies and equipment; and
- Transportation costs to transport individuals to day programs, social events or community activities when public transportation and/or transportation covered under the Medicaid state plan are not available will be included in payments made to providers of residential habilitation. Residential Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service.

Residential services will be billed on a daily rate for those recipients residing in certified residences and on an hourly rate for those residing in their family home, own home or apartment.

The service excludes the following:

- Services, directly or indirectly, provided by a member of the individual's immediate family;
- Routine care and supervision which would be expected to be provided by a family;
- Activities or supervision for which a payment is made by a source other than Medicaid; and
- Room and board costs.

Providers of residential habilitation must be certified by the Department of Mental Health and Mental Retardation. Small settings are encouraged. No new home will be certified for residence of more than six individuals, nor will new clusters of adjacent homes be certified. The only exception is that previously certified homes with more than six residents will be allowed to rebuild at the previous size, to allow the same individuals the choice to continue residing with people they know.

This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

Day Habilitation Services

Day habilitation includes planning, training, coordination and support to enable and increase independent functioning, physical health and development, communication development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self direction. Staff may provide assistance/training in daily living activities and instruction in the skills necessary for independent pursuit of leisure

time/recreation activities. Social and other adaptive skills building activities such as expressive therapy, prescribed use of art, music, drama or movement may be used to modify ineffective learning patterns and/or influence change in behavior.

Four levels of Day Habilitation have been identified, based on participant characteristics and the staffing ratios needed to support persons with those characteristics. There is a rate for each level.

Transportation cost to transport individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the client will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. Providers of day habilitation must be certified by the Department of Mental Health and Mental Retardation. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

Qualifications of the providers of day habilitation training are contained in Appendix B-2.

Prevocational Services

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

_____ Individuals will not be compensated for prevocational services.

__X__ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each

individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Providers of prevocational services must be certified by the Department of Mental Health and Mental Retardation. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

Supported Employment Services

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. X Yes (See Note) 2. _____ No

Note: Routine transportation, as by van within a 15 mile radius, is included in the fee for these services. This does not preclude other arrangements such as transportation by family or public conveyance.

Two models are included under which supported employment may be provided. The first is the current model, reimbursed on a per diem basis, consisting of at least 4 hours per day exclusive of transportation, of benchwork or mobile crew employment, in which the participant is typically employed by the waiver provider, although employment by the host business is allowed and encouraged. To further encourage full integration into work sites where individuals without disabilities are employed, and to take advantage of partnering with the State Vocational Rehabilitation Agency, a second model is offered, consisting of two services: individual job coach and job development. The scope of each service follows:

Individual Job Coach

Scope of Service
a. On the job training and skill development
b. Annual vocational assessment and update of vocational service plan
c. Training of co-workers on job site for accommodation and natural support
d. Facilitation of job accommodations and use of assistive technology
e. Job site analysis—matching job site needs with needs of participant
f. Education of participant and others on site regarding rights, responsibilities and the role of self-advocacy in the work place
g. Participation with the interdisciplinary team to support the person to achieve his chosen employment outcomes
h. Facilitating (eg arranging, or training for the use of public…) transportation, or if necessary actually transporting the participant to the work site. Note the staff is paid for his time, and the Personal Care Mileage code may be approved to cover mileage costs.
i. Documentation: includes progress on training goals, documentation of training provided, interventions and other supports provided, on a per day narrative basis.
j. This service includes time spent with the participant, but may also include time spent away from the participant working with the employer, the interdisciplinary team, other providers, or the individual’s family.

Limitations
a. The individual job coach service may not be provided on the same day as Day Habilitation, Pre-Vocational Habilitation, or Supported Employment, when those services are reimbursed on a per diem basis.

Job Development

Scope of Service
a. Development of initial career development plan with the participant
b. Performing a vocational assessment (this can also be done by the Individual Job Coach, but the initial assessment should be provided under Job Development)
c. Creating a vocational service plan within the context of person directed planning
d. Employer negotiation to develop placements
e. Job structuring—negotiating hours or location to meet the abilities of the participant
f. Job carving—within entry level jobs, participants will be better able to perform some tasks than others; the point is to sculpt a job for the participant that includes what he is able to do.
g. Placement—once placement is arranged, if job development has been performed by a person separate from the individual job coach, there needs to be a transfer period of up to 5 hours

Limitations
a. The job development can be provided for a participant on the same day as Day Habilitation, Pre Vocational Habilitation, or Supported Employment, when those services are reimbursed on a per diem basis.
b. There is an annual cap of 20 hours (80 units) per participant, which can be provided at the point when a person's desire for a job is manifested through the planning process. By exception, the Operating Agency may authorize a second 20 hour period within a year for an individual who has tried but failed, and wants to try again.

Interaction with the State Vocational Rehabilitation Program and the Ticket to Work:
Certified providers of Supported Employment and Day Habilitation who want to also provide Individual Job Coach and Job Development Services will be encouraged to become Ticket to Work providers or to enter into a contract with a Ticket to Work provider. The Ticket to Work Program, if the waiver participant is accepted, will pay for assessment, job development, job placement and short term job coaching. When the Ticket to Work Program reaches closure (stabilization) participants with multiple and/or severe disabilities typically need long term follow-up. This will consist of additional job coaching, at least several hours per month, and often more, for as long as the person is employed. The follow-up can also consist of personal care on the worksite, for

maintaining the participant's social skills and attention to task, among other personal care needs. The individual job coach hours will fade to a minimum when personal care is able to successfully support the person over the long term.

For those participants who are not accepted by the Ticket to Work Program, or who are, and try, but fail the first time, truly integrated Supported Employment is still attainable, and the waiver job development service, together with the individual job coach (and personal care on worksite) will be employed as long as the participant is willing to try to gain and hold employment.

Providers of Supported Employment must be certified by the Department of Mental Health and Mental Retardation. Provider qualifications are contained in Appendix B-2. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix J, version 3.5 of the HCBS waiver application.

h. Yes Environmental Accessibility Adaptations

X Other service definition (Specify):

Environmental Accessibility Adaptations

Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

The individual's home may be a house or an apartment that is owned, rented or leased. Adaptations to the work environment covered by the Americans with Disabilities Act, or those that are the responsibility of other agencies, are not covered. Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible.

Total costs of environmental accessibility adaptations shall not exceed $5,000 per year, per individual.

i. Yes **Skilled nursing:**

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

X **Other service definition (Specify):**

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Services consist of nursing procedures that meet the person's health needs as ordered by a physician. Services will be billed by the hour. There is no restriction on the place of service.

j. No **Transportation:**

_____ Other service definition (Specify):

k. Yes **Specialized Medical Equipment and Supplies**

X Other service definition (Specify):

Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per year, per individual.

l. No **Chore services:**

m. No **Personal Emergency Response Systems (PERS)**

n. Yes **Adult companion services:**

X Other service definition (Specify):

Adult Companion Services

Definition: Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not include hands-on nursing care. Providers may perform light housekeeping tasks that are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and not purely diversional in nature. This service is needed to prevent institutionalization. The QMRP will provide and document in the case record on-site supervision of the companion worker every 60 days. The supervisor will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performance by the worker.

Objective: Companion Services are to provide support and supervision that is focused on safety, non-medical care and socialization for clients participating in the MR waiver. Medicaid will not reimburse for activities performed which are not within the scope of services.

Services include:

a. Supervising daily living activities, to include reminding client to bathe and take care of hygiene and personal grooming, reminding client to take medication, and overseeing planning and preparation of snacks and meals.
b. Staying with client in the evening and at night to ensure security.
c. Accompanying client into the community, such as shopping.
d. Supervising/assisting with laundry, and performing light housekeeping duties that are essential to the care of the client.
e. Following written instructions such as the care plan and documenting services provided.

Requirements:

a. Services must be on the plan of care with documentation in the case record of need for service. The unit of service will be fifteen (15) minutes of direct companion services provided to the client.
b. The provision of the service, and the number of units of service provided to each client, is dependent upon the individual client’s needs as set forth in the client’s plan of care.
c. Companion service is not available to group home residents.
d. No payment will be made for companion services furnished by a member of the recipient’s family.
e. Companion services are limited to functionally impaired adults (age 21 and over).
f. Companion service is non-medical and does not include hands-on care.

Provider qualifications are contained in Appendix B-2.

o. No **Private duty nursing:**

q. No **Attendant care services:**

r. No **Adult Residential Care (Check all that apply):**

s. Yes **Other waiver services** which are cost-effective and necessary to prevent institutionalization (Specify)**: Assistive Technology, Speech and Language Therapy, Physical Therapy, Occupational Therapy, Behavior Therapy, Community Specialist Services, and Crisis Intervention.**

Assistive Technology

Assistive technology service includes devices, pieces of equipment or products that are modified, customized, and are used to enable severely handicapped individuals maintain or improve his/her activities of daily living; or to perceive, control, or communicate with the environment in which he/she lives. Also, included are assessments and specialized training needed in conjunction with the use of such equipment.

Assistive technology must be prescribed by a physician, be medically necessary, and listed on the care plan. Prior authorization by the Medicaid Agency is required. The need for this service must be documented in the case record.

Provider qualifications are found in Appendix B-2

Speech and Language Therapy

Speech and language therapy are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). These services may include:

Screening and evaluation of individuals' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

Participation in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals' habilitation programs; and

Treatment services as an extension of the evaluation process that include:

- consulting with others working with the individual for speech education and improvement,
- designing specialized programs for developing an individual's communication skills comprehension and expression.

Provision of this service will prevent institutional placement.

Therapist may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Services must be listed on the care plan and prescribed by a physician. The need for service must be documented in the case record. Services shall be provided and billed by the hour. Speech/language therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered. Provider qualifications are found in Appendix B-2.

Physical Therapy

Physical therapy is physician prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to:

- preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and

- prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Provision of this service will prevent institutional placement.

Therapist may also provide consultation and training to staff or caregivers (such as client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Documentation in the case record must justify the need for service. Services must be listed on the care plan and be provided and billed by the hour. Physical therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to

recipients age 21 and over. Group therapy is not allowed.

Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered. Provider qualifications are found in Appendix B-2.

Occupational Therapy

Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term "occupation" as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performances. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning. Provision of this service will prevent institutional placement.

Therapist may also provide consultation and training to staff or caregivers (such as client's family and /or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Services must be prescribed by a physician and be provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan and be provided and billed by the hour. Occupational therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy is not allowed.

Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered. Provider qualifications are found in Appendix B-2.

Behavior Therapy

Behavior Therapy Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration, whose health is at risk, and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may also include consultation provided to families, other caretakers, and habilitation services providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive

behavior rather than merely the elimination or suppres**sion** of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried, and it's continued use must be reviewed thirty days. The unit of service is 15-minutes.

The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a Behavior Support Plan (BSP) and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

The table that follows lists types of tasks that meet criteria for billing for Behavior Therapy Services. Tasks listed are intended to be interpreted broadly to include any activities related to BSP development and implementation recognized in the field of behavior analysis.

Behavior Support Plan Development
Functional Analysis/Assessment(can include, but is not limited to, experimental analog procedures, conducting interviews, completion of screening measures, direct observation, review of ABC data, and other activities related to gathering information regarding the function of behavior)
ID/define target behaviors (includes behaviors to decrease and/or those to increase)
ID/assess psychiatric symptoms, if applicable
Participate in Interdisciplinary Team (IDT) meetings for BSP planning/development
ID/describe preventive strategies/other interventions
Write the plan (includes writing of BSP/psychotropic medication plan, if appropriate, as well as writing of addendum/revisions to the plan)
Implement baseline and analyze baseline data (includes training staff regarding baseline data collection)
Conduct reinforcer/preference assessment
Design data sheets
Behavior Support Plan Implementation
Present BSP/psychotropic medication plan for approval by Behavior Review Committee (BRC) and Human Rights Committee (HRC)

Periodic BSP follow-up and revision (includes activities such as reliability checks, attending IDT meetings related to BSP implementation and follow-up,)
Progress/evaluation reports
Activities evaluating impact of psychotropic medications
Staff training relevant to the BSP (includes initial and any follow-up training related to the BSP/psychotropic medication plan/use of data sheets, etc.)
Data entry, graphing, summary

Average 15-minute units of Behavior Therapy Services required per person per year range from 120 to 600 units. About one third of any significant behavior analysis effort consists of tasks that could be provided by technical level providers, with supervision. Therefore, the maximum units per year of both professional and technician level units in combination cannot exceed 600 and the maximum units of professional level cannot exceed 400. Maximum units of Technician level service are the balance between billed professional level units and the combined maximum per year. Professional level providers may provide more than the 400 unit limit, but these additional units will be paid at the Technician level. Providers of service must document which tasks are provided by date performed in additional to their clinical notes. Group therapy will not be reimbursed.

Service providers who identify individuals who require Behavior Therapy services in excess of the caps indicated above may request consideration for approval of additional service units by the Director of Psychological and Behavioral Services in the Division of Mental Retardation of the DMH/MR. Detailed explanations (accompanied by documentation supporting the explanations) regarding how additional units of service will benefit the individual, data supporting the need for additional services, the written Behavior Support Plan, and documentation indicating how all of the units of service provided up to that point have been used will be required for review. Additional service units will be approved if sufficient evidence is presented to justify the need. There will be limits set regarding the number of units approved at that time. If there is insufficient evidence to support the request for additional service units, the request will be denied.

Providers of service must maintain a service log that documents specific days and hours on which behavior therapy services were delivered.

This service is necessary to prevent institutionalization. Provider qualifications are found in Appendix B-2.

Community Specialist Services

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members,

consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports. Here again, these functions differ from case management in that activities of planning and implementing services with self-determination are the focus. The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. The services of the community specialist will assist the consumer and his caregivers to design and implement specialized programs to enhance self-direction, independent living skills, community integration, social, leisure and recreational skills, and behavior management. A community specialist with expertise in person- centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resources locating, monitoring and assessment.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period of time, the targeted case manager will need only visit the person every 180 days, and call the person at 90-day intervals to ensure services actually are being delivered and are satisfactory. The community specialist will share information with the case manager quarterly in an effort to remain abreast of the client’s needs and condition. A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

This service is a cost effective and necessary alternative to placement in an ICF-MR. A unit of service is one hour.

Crisis Intervention

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting in which

the consumer resides or participates in a program. The service includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with mental retardation are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises. This service is a cost effective alternative to placement in an ICF-MR.

Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting. There are two levels of staff, professional and technician. A unit of service is one hour. Qualifications for providers of this service are defined in Appendix B-2.

When the need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved by the regional community service office of the DMH/MR prior to the service being initiated.

Specific crisis intervention service components may include the following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
- Developing and writing an intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
- Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer’s crisis situation; and
- Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

Providers of service must maintain a service log that documents specific days and hours on which crisis intervention services were delivered. Provider qualifications are found in Appendix B-2.

t. No **Extended State plan services:**

u. No **Services for individuals with chronic mental illness:**

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administration Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION/ACCREDITATION	OTHER STANDARD
Personal Care Services	• Employee of or under contract with an Agency			• *See Appendix B-2 Addendum*
Respite Care	• In- Home: • Employee of an Agency Out of Home: • Community Residential Facility, • ICF/MR, or • Hospital or Residential Treatment Facility		• Al. Code Chapters 580-3-23, and 580-5-30A/B • Al. Code Chapters 580-3-23, and 580-5-30A/B • Certified by Alabama Department of Public Health • JACHO Accredited	• *See Appendix B-2 Addendum* • *See Appendix B-2 Addendum,*
Residential Habilitation	• Employee of a certified Community Residential Agency		• Al. Code Chapters 580-3-23, and 580-5-30A/B	• *See Appendix B-2 Addendum,*
Day Habilitation	• Certified Day Program		• Al. Code Chapters 580-3-23, and 580-5-30A/B	• *See Appendix B-2 Addendum,*
Prevocational Services	• Certified Prevocational Program		• Al. Code Chapters 580-3-23, and 580-5-30A/B	• *See Appendix B-2 Addendum*
Supported Employment	• Certified Supported Employment Program		• Al. Code Chapters 580-3-23, and 580-5-30A/B	• *See Appendix B-2 Addendum*

SERVICE	• PROVIDER	• LICENSE	CERTIFICATION/ACCREDITATION	OTHER STANDARD
Environmental Accessibility Adaptations	• Contractor	• Meets all applicable State and Local Licensure requirements		• All construction, wiring, plumbing meets applicable building codes
Skilled Nursing	• Registered Nurse	• Code of Alabama, 1975 Sec. 34-21		• *See Appendix B-2 Addendum,*
Specialized Medical Equipment and Supplies	• Individuals and Businesses able to supply and service supplies and equipment.			• Meet same standard as providers under the State Plan EPSDT program.
Adult Companion Services	• Individual employed or contracted by a certified agency.			• See Appendix B-2 Addendum
Assistive Technology	• Individuals employed or contracted by a certified agency.			• Meet same standard as Providers under the State Plan EPSDT program.
Speech and Language Therapy	• Speech Therapist	• Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7		
Physical Therapy	• Physical Therapist	• Code of Alabama, 1975 Sec. 34-24-212		
Occupational Therapy	• Occupational Therapist	• Code of Alabama, 1975 Sec. 34-39-5		
Behavior Therapy	• Board Certified Ph.D. or MA level Behavior Analyst, or • Ph.D. psychologist without Board Certification, or		• Behavior Analysis Certification Board (www.BABC.com)	• and three years experience working with persons with disabilities. • And three years experience working with persons with disabilities and under supervision • Qualify as a QMRP, 42 CFR 483.430; with training and

	• MA psychologist without Board Certification, or • QMRP or BA level Associate Behavior Analyst			experience in applied behavioral analysis / positive behavior support. • *See Appendix B-2 Addendum,*
Community Specialist Services	• BA level QMRP with special training and experience			• *See Appendix B-2 Addendum,*
Crisis Intervention	• Team directed by Graduate Psychologist or Social Worker			• *See Appendix B-2 Addendum,*

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure of certification requirements are met for services individuals furnishing services that are provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

DMH/MR CONTRACT: PROVIDER REQUIREMENTS

All waiver providers must have a contract with the Department of Mental Health and Mental Retardation (DMH/MR) for the delivery of the specific service(s) they will provide. Providers may not enroll with Medicaid as a waiver provider without first obtaining a contract with DMH/MR. The provider must maintain a current contract in order to continue as an active waiver provider.

QUALITY ASSURANCE

A. Certification standards are published in the Alabama State Code. These are the standards for certification of residential and day habilitation, prevocational and supported employment providers. The certification process administered by the DMH/MR allows high scoring providers to be certified for two years; successful but lower scoring providers to be certified for one year, and sets up a process for conditional certification with possible termination for those providers which do not achieve a satisfactory certification.

B. The Division of Mental Retardation maintains 5 regional community service offices which house Continuous Quality Improvement (CQI) staff as well as other professional staff who provide technical assistance and monitoring to community providers. Other officials of the DMH/MR housed at the community service offices are Advocates, which conduct investigations.

   If a provider refuses to cooperate in taking corrective action, the Division can initiate intermediate sanctions such as discouraging new admissions or encouraging the development of new providers in the area. When necessary, the Division can remove individuals from services and terminate a provider's DMH/MR contract if necessary.

C. The Division of Mental Retardation has joined other state MRDD agencies participating in the NASDDDS/HSRI sponsored Core Indicators project. The initial effort will be to implement a consumer and family survey process using volunteer consumers and family members. Volunteers will schedule visits with the permission of the person and throughout the process maintain focus on the person and his or her choices, inclusion, rights, dignity, and quality of life. The purpose will be to determine if the individual is leading as full a life as possible, not to review local, state or federal standards.

D. The Alabama Department of Medicaid conducts surveys of all waiver providers and case management agencies as well. Findings are shared with the DMH/MR for technical assistance and follow-up, unless serious problems are found. In such a case the DMH/MR would initiate either an investigation or a targeted certification review, as necessary.

ADDITIONAL SERVICE STANDARDS

PERSONAL CARE SERVICES

Provider Qualifications

Personal care workers may be employed by, or under contract with, any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals, that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QMRP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting. The primary requirements for the provider agency are to:

- Handle all payroll taxes required by law,
- Provide training and supervision as required by this scope of services,
- Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care,
- Implement a plan and method for providing backup at any time it is needed,
- Implement and assure the person and his or her family are and remain satisfied with the service.

Personal Care Workers:

- Must have at least two references from work and/or school, and one personal, which have been verified by the provider agency.
- Must have background checks required by law and regulation.
- Must be at least 18 years of age.
- Must be able to read and write and follow instructions.
- Must have at least completed tenth grade.
- Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition.
- Must have no physical or mental impairment that would prevent providing the needed assistance to the person.
- If providing transportation, must have valid driver's license and insurance as required by State Law.

Personal Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported, nor shall they be in any other way legally obligated to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

Training Requirements

This service is intended to promote self-determination of waiver participants. To the extent practical, safe and cost effective, the

individual and his family are encouraged to exert choice in planning, and in the selection and hiring of staff, and are encouraged to provide training and supervision to the worker(s). Agencies are encouraged to partner with individuals and families in this endeavor, while providing a safe and effective backup system to meet contingencies.

Training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the personal care worker, including following the Personal Care Plan of Care, the rights and responsibilities of the provider and the consumer, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the provider agency or regional office.

- Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.

- Training in CPR and first aid and, if administration of ordinarily self-administered medication is required by the consumer, training in medication administration. As needed due to challenging behavior by the consumer, the worker will also be trained in behavioral intervention techniques appropriate to the consumer. Training in medication administration and behavior intervention techniques may be waived if not required to support the person.

- Training in communication skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familiar and social relationships; in handling conflict and complaints and in responding to emergencies.

- Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the consumer and identified by the planning team.

- The provider will maintain a record of training.

Supervision

Supervision shall not be left solely to the family or individual, even though family and individual are in most instances entirely competent to provide such supervision. A QMRP from the provider agency must visit the person, in person, at least every 90 days. The planning team shall recommend a visit schedule in the personal care addendum. The visiting QMRP shall make an assessment of the effectiveness of the service, the consumer satisfaction with the service, and of any changes that may need to be made, including additional training or a change in the plan of care. This record shall be shared with the provider agency and the individual and his or her family.

Documentation

The direct service provider and/or billing provider must maintain documentation of the dates and hours of service provided, and of the service activities provided within each span of work showing that services delivered are consistent with the recipient's individual plan of care. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer and the consumer's Medicaid number, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the specific activities provided within each span of work, will be acceptable as a minimum. In addition, there must be evidence of a quarterly review of the services provided and of the continued appropriateness of those services by a QMRP.

RESPITE CARE

Respite Care provided in a person's home

Provider Qualifications

Respite care workers may be employed by any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QMRP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.
The primary requirements for the provider agency are to:

- Handle all payroll taxes required by law,
- Provide training and supervision as required by this scope of services,
- Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care,
- Implement a plan and method for providing backup at any time it is needed,
- Implement and assure the person and his or her family are and remain satisfied with the service.

Respite Care Workers:

- Must have background checks required by law and regulation.
- Must be at least 18 years of age.
- Must be able to read and write and follow instructions.
- Must have at least completed tenth grade.
- Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition.
- Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person.

Respite Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being

supported. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

Training Requirements

To the extent practical, safe and cost effective, the individual and his family are encouraged to exert choice in the selection and hiring of staff, and are encouraged to provide training to the worker(s). Agencies are encouraged to partner with individuals and families in this endeavor, while providing a safe and effective backup system to meet contingencies.

Training shall be provided prior to the worker delivering services and includes:

1. The rights and responsibilities of the provider and the consumer, procedures for billing and payment, record—keeping requirements and who to contact within the regional center.

2. Information about the specific condition and needs of the person to be served, and training in the care and assistance the respite worker will need to provide.

3. Training or verification of training in CPR and first aid and, if needed, training in medication administration and/or behavioral intervention techniques approved by the regional centers (these include MANDT techniques and PCI--Physical Crisis Intervention).

The provider will maintain a record of training.

Supervision

A QMRP from the provider agency must accompany a new worker to his or her first assignment, to observe and assist as the ordinary caregiver tells the worker what needs to be done to support the person being cared for. The QMRP may leave when the caregiver does, but needs to debrief the worker within a week after the assignment is completed. Additional visits may need to be made to assist the worker, especially with situations where the respite is to be provided to a person with special medical or behavioral needs or problems. Supervision must be tailored to the individual being served. The supervisor shall either be on call for the worker while respite is being provided or shall ensure the worker has a back-up number to call. The supervising QMRP shall record an assessment of the worker's competence and comfort working with people with mental retardation, and shall always contact a family served by the worker to determine and record their satisfaction with the service and any other information they wish to share.

Documentation

The billing provider must maintain documentation of the days and hours of service provided. Logs signed by the worker and cosigned by the consumer or family member are acceptable.

RESIDENTIAL HABILITATION SERVICES

The Department of Mental Health and Mental Retardation, Division of Mental Retardation requires certification of programs delivering Residential Habilitation services. Standards are in Alabama Code, Chapters 580-3-23, and 580-5-30 A and B.

An applicant wishing to provide Residential Habilitation Services must provide written statements of certification of the facility's compliance with fire and health standards where applicable and submit these and other documentation to the Division of Mental Retardation. If residential habilitation is provided in the individual's home (including family home), then the structure is not reviewed by DMH/MR for compliance with fire and health standards.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certificate will be issued by the Division of Mental Retardation.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Residential Habilitation services shall have written a written mission statement for dissemination to prospective clients and their families. This mission statement shall address:

Program philosophy and purpose;
Geographical area served;
Range of services provided; and
Population served, including criteria for service eligibility, program admission and program discharge.

Each Residential Habilitation program must develop and maintain appropriate, up-to-date staffing schedules for each facility. Program staff ratios and staff work schedules shall be maintained to meet the needs of clients. An emergency, on-call staff person, in addition to those normally required to maintain appropriate staffing patterns, shall be available. Staff scheduling and work place assignments shall be so arranged as to provide continuous on-site response capability in the event of client needs. The staffing pattern shall be appropriate to the type and scope of programmed services and shall include staff members who meet qualifications set forth in the approved job descriptions. If a program is contracted to serve clients who require considerable guidance and supervision (i.e., moderately and severely physically handicapped clients, clients who are aggressive, assaultive or are security risks, or clients who exhibit severely hyperactive or psychotic behavior), the daily ratio of training staff to clients may vary from 1:1 to 1:8, depending on programmatic and support need. This ratio shall be justified and documented. If a program is contracted to serve clients requiring training or assistance in basic independent living skills, the training staff-to-client daily ratio shall not exceed 1:10.

Residential Habilitation services will be delivered/supervised by a

Qualified Mental Retardation Professional in coordination with the individual's plan of care.

Residential Habilitation provided in a person's natural home or setting other than a group home.

Program staff ratios and staff work schedules shall be maintained to meet the needs of the client. An emergency, on-call staff person shall be available. Staff scheduling and work place assignments shall be so arranged as to provide continuous on-site response capability in the event of client needs. The staffing pattern shall be appropriate to the type and scope of programmed services. Staff shall meet qualifications in the approved job descriptions.

Staff Qualifications: Habilitation Aide-Residential Habilitation

The Aide will work under supervision and direction of a Qualified Mental Retardation Professional. The QMRP must provide and document supervision of, training for, and evaluation of Aide in the individual client's record. The QMRP must assist the Aide as necessary as they provide individual habilitation services as outlined by the plan of care.

Minimum Qualifications:

The Aide must be 18 years of age and must possess a high school diploma or G.E.D.

Training Requirements:

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR which will minimally include:

1. Recipient rights and grievance procedures.
2. Overview of mental retardation and developmental disabilities.
3. Concepts of human development.
4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/ universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above.

Providers must have documented record of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the consumer's plan of care.

DAY HABILITATION, PREVOCATIONAL, AND SUPPORTED EMPLOYMENT SERVICES

The Department of Mental Health and Mental Retardation, Division of Mental Retardation requires certification of programs delivering Day

Habilitation, Prevocational and Supported Employment services. Standards are in Alabama Code, Chapters 580-3-23, and 580-5-30 A and B.

An applicant wishing to provide any one or combination of these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of Mental Retardation.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certification certificate will be issued by the Division of Mental Retardation.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the Department's Division of Technical Services. Programmatic re-surveys are conducted at one or two year intervals depending on the previous survey outcome.

Programs delivering Day Habilitation, Prevocational and/or Supported Employment services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

Program philosophy and purpose;
Geographical area served;
Range of services provided; and
Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15. No client shall ever be left unsupervised unless the activity is part of a structured activity or individual activity plan (IAP).

Day Habilitation Training: Requirements specific to this service.

Habilitation Aide – Job Specifications

Day Habilitation training services will be delivered by a habilitation aide and supervised by a Qualified Mental Retardation Professional (QMRP) in coordination with the individual's plan of care.

The Aide will work under supervision and direction of a Qualified Mental Retardation Professional. The QMRP must provide and document supervision of, training for, and evaluation of Aide in the individual client's record. The QMRP must assist the Aide as necessary as they provide individual Habilitation services as outlined by the plan of care.

Minimum Qualifications:

Must be 18 years of age and must possess a high school diploma or G.E.D.

Training Requirements:

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR which will minimally include:

10. Recipient rights and grievance procedures.
11. Overview of mental retardation and developmental disabilities.
12. Concepts of human development.
13. CPR, first aid, medical emergencies.
14. Management of challenging behavior.
15. Physical management techniques.
16. Health observation, including hygiene, medication control/ universal precautions.
17. Recipient abuse, neglect and mistreatment.
18. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above.

PREVOCATIONAL SERVICES: Requirements specific to this service.

In addition to certification, the following requirements apply to the provider's staff.

Activity Program Aide: Job Specifications

The minimum requirement for this position is graduation from high school or its equivalent and two years work experience. A Bachelors Degree with a major concentration in rehabilitation, industrial arts, pre-vocational education, psychology or a related field is preferred along with experience supervising or training and knowledge of persons with disabilities.

Specific Duties: The Activity Program Aide will work under the supervision and direction of a QMRP. The QMRP will provide and document on-site supervision every 30 days. Supervisor reports must be maintained in the personnel file and are subject to review by DMH/MR and Alabama Medicaid Agency.

The duties of the Activity Program Aide (Pre-Vocational) include:

1. Instructs/demonstrates/interacts with clients concerning a variety of education, personal care, pre-vocational training, job safety, and social behaviors, in accordance with the individual's habilitation plan and program requirements. Uses sound judgment and abides by supervisor's instructions, minimum standards and other applicable regulatory standards in order to foster client self-sufficiency and independence.

2. Converses with/listens to clients concerning personal needs, responsibilities, expectations, aspirations, privileges, and personal/behavioral problems in a supportive and understanding manner.

3. Participates in developing, modifying, and adapting instruction and training to individual client needs.

4. Interacts often and appropriately with clients using both verbal and nonverbal methods (gestures, modeling, sign language, etc.) to provide information to clients about expected behavior, duties, and activities.

5. Observes the quality of production and integrates efficiency concepts in the work process.

6. Provides/receives information to/from peers, supervisors, other professional staff, support personnel, and clients pertaining to care plan, schedules, programs, and progress using personal contacts, meetings, memorandums, reports, records and filing systems in accordance with established schedules in order to facilitate client training, record maintenance and the exchange of other pertinent information.

7. Assists in computing data for programs such as behavior management, speech, token reinforcement, vocational, and social in order to assess client progress.

Training Requirements

The Activity Program Aide (Pre-Vocational) training should demonstrate interaction with recipients concerning education, personal care, pre-vocational training, job safety and social behaviors, in accordance with the recipient's habilitation plan and care plan. The minimum training requirements:

1. Planning and coordinating all activities according to the individual habilitation and care plan.
2. Leadership with recipients doing therapeutic or rehabilitative activities programs.
3. Conferring with other professional personnel concerning the progress and needs of the recipients.
4. Providing individual instruction when needed.
5. Health observation including hygiene medication control/universal precautions.
6. Recipient abuse, neglect and mistreatment.
7. Knowledge of equipment and supplies needed for assigned activities.
8. Recipients rights and grievance procedures.
9. CPR first aid, medical emergencies.
10. Training on how to read and comprehend written materials, such as the care plan, habilitation plans and policy and procedures manuals.

Ongoing training will be conducted as needed but at least annually for above training requirements 6 and 8.

Additional Provider Requirements

The provider of service

- Must have required training prior to providing service;
- Must keep record of required training in the personnel folder; and
- Must maintain a service log that documents specific days on which services were delivered consistent with the recipient's individual plan

of care.

SUPPORTED EMPLOYMENT SERVICES: Requirements specific to this service.

In addition to certification, the following requirements apply to the provider's staff.

Job Trainer (Job Coach)(Note this is a staff within the per diem service) Qualifications:

The minimal requirement for this position is graduation from high school or its equivalent and two years work experience. A Bachelors Degree with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities is particularly desirable.

Job Specification:

The Job Trainer is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of clients involved in Supported Employment. The Trainer works under the direction of a QMRP.

The specific duties of the Job Trainer (Job Coach) include:

SPECIFIC DUTIES:

The duties of the Job Trainer (Job Coach) include:

1. Training supported work clients to perform specific jobs consistent with their abilities;

2. Working with employers to modify or adapt job duties or work stations so supported work clients can have the maximum opportunity for job success. This may involve job and task analysis, employer interviews, and actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the client:

3. Teaching clients associated work skills, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks, safety precautions, etc.;

4. Assisting each client placed in a job training program to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the client worker or other employees to communicate with each other, or the provision of disability awareness of training to worker's of the company;

5. Working with client to be placed in employment and/or with client's family or residential provider to insure that client has reliable transportation to and from work, adequate housing, and emotional support for client's job efforts;

6. Making every effort to insure that the supported work client and the job are satisfactory matched by thoroughly getting to know each client prior to job placement. This may include reviewing current progress in client's present program placement, studying referral information, and working with client to assess work skills;

7. Communicating through written and oral reports on progress of Supported Work Clients to Program Director and other program staff; follow oral or written instructions (such as the care plan or rehabilitation plan);

8. Providing continued ongoing support to supported work clients;

9. Performing other job duties necessary to ensure the success of Supported Work Clients as well as any additional tasks assigned by the Program Director that will be of benefit to other clients in the program.

10. Documenting progress on training goals, training provided, interventions and other supports provided, on a per day narrative basis.

TRAINING REQUIREMENTS:

The training program for the Job Coach will reinforce the responsibility to ensure successful employment of recipients involved in supported employment. The Job Coach will be required to be certified by completing the requirements provided by a QMRP, approved by DMH/MR. Training completion must be documented and is subject to review by DMH/MR and Alabama Medicaid. Minimum training requirements must include the following areas:

1. Overview of mental retardation and developmental disabilities
2. Skills to identify recipient abuse, neglect and mistreatment
3. Recipients rights and grievance procedures
4. Planning and conducting appropriate activities to support the person in finding and maintaining employment.

Ongoing training will be conducted as needed.

Individualized Job Coach (Note this staff is reimbursed for a 15 minute unit)

Qualifications:
The minimal requirement for this position is: graduation from high school or its equivalent and one year's work experience working with persons with an intellectual disability. A Bachelors Degree with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. The applicant shall also have a background check and drug testing as required by certification standards.

Job Specification:
The Individual Job Coach has the same Job Specifications as the Job Trainer above, and is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of clients involved in Supported Employment. The Individual Job

Coach works under the direction of a QMRP.

The specific duties of the Individual Job Coach include:

1. Training Supported Employment Clients to perform specific jobs consistent with their abilities within an integrated work setting where individuals without disabilities are also employed;
2. Working with employers to modify or adapt job duties or work stations so Supported Work Clients can have the maximum opportunity for job success. This may involve job and task analysis, employer interviews, and actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the client:
3. Teaching clients associated work skills, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks, safety precautions, etc.;
4. Assisting each client placed in a job-training program to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the client worker or other employees to communicate with each other, or the provision of disability awareness of training to worker's of the company;
5. Working with the client to be placed in employment and/or with client's family or residential provider to insure that client has reliable transportation to and from work, adequate housing, and emotional support for client's job efforts;
6. Making every effort to insure that the Supported Work Client and the job are appropriately matched by thoroughly getting to know each client prior to job placement. This may include reviewing current progress in the client's present program placement, studying referral information, and working with the client to assess work skills;
7. Communicating through written and oral reports on progress of Supported Work Clients to Program Director and other program staff; following oral or written instructions (such as the care plan or rehabilitation plan);
8. Providing continued ongoing support to Supported Work Clients;
9. Performing other job duties necessary to ensure the success of Supported Work Clients as well as any additional tasks assigned by the Program Director that will be of benefit to other clients in the program.
10. Documenting progress on training goals, training provided, interventions and other supports provided, on a per day narrative basis.

Training Requirements:

In addition to the training required by certification standards, the individualized job coach shall have training in career development planning and vocational assessment.

The training program for the Job Coach will reinforce the responsibility to ensure successful employment of recipients involved in Supported Employment. The Job Coach must be certified by a QMRP as having completed training required by DMH/MR. This certification must be documented and is subject to review by DMH/MR and Alabama Medicaid. Minimum training requirements shall include the following areas:

1. Overview of mental retardation and developmental disabilities
2. Skills to identify recipient abuse, neglect and mistreatment

3. Recipient rights and grievance procedures
4. Planning and conducting appropriate activities to support the person in finding and maintaining employment.

Job Development

Minimal qualification for the person providing this function is a four year college degree and at least one year working experience with individuals with intellectual disabilities.

Additional Training Requirement

The person providing job development shall have had the career development planning and vocational assessment training required of the individualized job coach.

Benefits Management

Benefits Management is extremely important, so that successful participants don't earn themselves out of waiver eligibility and wind up, for instance, without a home. The certified agency which provides supported employment must understand this importance and shall provide benefits management oversight by a QMRP as a basic required function. There is no separate payment for this component of the service.

ADULT COMPANION SERVICES

Minimum Qualifications:

All individuals providing this service must meet the following qualifications:

1. Completion of the sixth grade and some responsible non-professional supportive services experience. Graduation from a standard senior high school may be substituted for the required experience.
2. Ability to read and write.
3. Ability to establish and to maintain effective working relationships with clients.
4. Ability to demonstrate emotional maturity and to show the proper attitude toward clients.
5. Ability to understand and to follow simple oral and written instructions.

Training Requirements:

Prior to assignment, each companion worker must be certified by the provider agency as having completed a course of instruction provided or approved by DMH/MR. The course of instruction must be documented in writing and is subject to review by DMH/MR and Medicaid. Minimally this instruction will include:

1. Overview of mental retardation,
2. Appropriate skills required for managing various behaviors,
3. Physical management techniques,
4. Health observation including medication control/universal precautions,
5. Recipient abuse, neglect and mistreatment policies,
6. Recipient rights and grievances procedures,
7. Written materials such as the care plan, habilitation plan and policy and procedures manuals, and
8. CPR, first aid, medical emergencies.

SKILLED NURSING

The provider shall be a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in consumer's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note.

BEHAVIOR THERAPY SERVICES PROVIDER QUALIFICATIONS

Three levels of provider may provide Behavior Therapy. The qualifications are as follows:

Level 1: Providers at Level 1 must have either a Ph.D. or M.A. **and** be certified as a Behavior Analyst (BCBA) by the Behavior Analysis Certification Board.

Behavior Analysis Certification Board
3323 Thomasville Road, Suite B
Tallahassee, FL 32308
Phone (850) 386-4444; FAX (850) 386-2404; Web www.BACB.com

Level 2: Providers must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision. Master's degreed individuals require supervision averaging two hours per week by a Level 1 provider or a Level 2 Ph.D. provider.

Level 3: Providers must be either a QMRP (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst (BCABA). With two years of experience and authorization by the Administering Agency, the BCABA may qualify as a Level 2 provider with supervision.
All Behavior Therapy service providers must complete an Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Areas of training are: Levels of Risk; Levels of Intervention; Behavior Program Review Committee; Data Collection, Graphing, and Reporting. The Behavior Support Plan (Content & Process) will also be trained.

The orientation of Level 1 and level 2 providers will be provided by the DMH/MR. With approval of DMH/MR, level 1 and level 2 providers can then provide the orientation to level 3 providers and also to other Professional Level providers. The DMH/MR will maintain a registry of trained Behavior Therapy Providers and record of their orientation. The DMH/MR will also maintain a record of who is providing the supervision to those level 2 non-Ph.D. providers and level 3 providers who require supervision.

COMMUNITY SPECIALIST SERVICES

The provider must meet federally defined QMRP qualifications (42 CFR 438.430) and be free of any conflict of interest. This means he or she cannot work for any provider or provider agency from which a person is receiving, or is likely to receive, services reimbursed through this waiver program.

In addition, the provider must have experience, verified by the DMH/MR, in person centered planning. This will consist of both training and actual practice.

CRISIS INTERVENTION

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Alabama, and meeting the requirements of a QMRP (as defined at 42 CFR 483.430). All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services. The team shall be mobile and prepared to provide direct staffing if that is necessary to implement the plan.

Crisis teams may be agency based (certified waiver residential and day habilitation providers, or DMH/MR Developmental Centers), or they may stand alone. Because this is a new service, the initial teams will be employed by the DMH/MR Developmental Centers, because of the knowledge and experience in crisis prevention and intervention gained by staff of these facilities. The time and expenses of these staff when operating in the community or otherwise on behalf of a waiver recipient, will be maintained in a separate cost center to segregate these costs from the ICF/MR program.

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

X A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

Group Homes are certified by DMH/MR. ICF/MRs and Hospitals, in which respite may be provided, are certified by the Alabama Department of Public Health.

SECTION 1915 (c) WAIVER **FORMAT**

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. **X** Low income families with children as described in section 1931 of the Social Security Act.

2. **X** SSI recipients (SSI Criteria States and 1634 States).

3. _____ Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. _____ Optional State supplement recipients

5. _____ Optional categorically needy aged and disabled who have income at (Check one):

   a. _____ 100% of the Federal poverty level (FPL)

   b. _____% Percent of FPL which is lower than 100%.

6. **X** The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

_____ A. Yes _____ B. No

Check one:

a. _____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. **X** Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) __ A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

___ % of FBR, which is lower than 300% (42 CFR 435.236)

$ ___ which is lower than 300%

(2) ____ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program.(42 CFR 435.121)

(3)____ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)____ Medically needy without spenddown in 209(b) States.(42 CFR 435.330)

(5)____ Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)____ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7._____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8._____ All other mandatory and optional groups under the plan are included.

Appendix C-2--Post-Eligibility

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. **X** **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. **X** The following standard included under the State plan (check one):

(1)_____ SSI

(2)_____ Medically needy

(3)_____ The special income level for the institutionalized

(4)_____ The following percent of the Federal poverty level):_____ %

(5) **X** Other (specify): 300% of FBR

B._____ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

C._____ The following formula is used

to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A. X SSI standard

B. _____ Optional State supplement standard

C. _____ Medically needy income standard

D. _____ The following dollar amount: $ _____*

*If this amount changes, this item will be revised.

E. _____ The following percentage of the following standard that is not greater than the standards above: _____ % of

standard.

F. _____ The amount is determined using the following formula:

G. _____ Not applicable (N/A)

3. Family (check one):

A. _____ AFDC need standard

B. _____ Medically needy income standard

The amount specified below cannot exceed the higher of

the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C._____ The following dollar amount: $_____*

*If this amount changes, this item will be revised.

D._____ The following percentage of the following standard that is not greater than the standards above: %_____ of _____ standard.

E._____ The amount is determined using the following formula:

F. Other

G._____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b)_____ **209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

(1) individual: (check one):

A._____ The following standard included under the State plan (check one):

(1)_____ SSI

(2)_____ Medically needy

(3)_____ The special income level for the institutionalized

(4)_____ The following percentage of the Federal poverty level:_____%

(5)_____ Other (specify):

B._____ The following dollar amount: _____*

* If this amount changes, this item will be revised.

C._____ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A._____ The following standard under 42 CFR 435.121:

B._____ The medically needy income standard_____;

C._____ The following dollar amount: $_____*

*If this amount changes, this item will be revised.

D._____ The following percentage of the following standard that is not greater than the standards above: _____% of

E._____ The following formula is used to determine the amount:

F._____ Not applicable (N/A)

3. family (check one):

A._____ AFDC need standard

B._____ AFDC payment standard

C._____ Medically needy income standard

D._____ The following dollar amount:

$_____*

*If this amount changes, this item will be revised.

E._____ The following percentage of the following standard that is not greater that the standards above: _____% of standard.

F._____ The following formula is used to determine the amount:

G._____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2._____ The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(1)_____ Institutional PNA: Specify the amount:$_____*

*Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community:

(2)_____ An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses. (check one):

(a)_____ SSI Standard

(b)_____ Medically Needy Standard

(c)_____ The special income level for the institutionalized

(d)_____ The following percent of the Federal poverty level:_____%

(spouse)_____ Other (specify):

(f)_____ The following dollar amount$_____**

**If this amount changes, this item will be revised.

(g)_____ The following formula is used to determine the needs allowance:

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

__X__ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

Addendum to Appendix D-1: Procedures by which people apply for and are determined eligible or not-eligible for the Home and Community-Based Waiver.

Local public planning authorities, known as designated 310 agencies after the legislation authorizing their creation, officially represent each county of the State of Alabama. These local authorities are the providers of targeted case management for persons with Mental Retardation and are also the designated points of application to the Department of Mental Health and Mental Retardation. As such, the 310 agencies are expected to coordinate applications for enrollment in the Home- and Community-Based Waiver for Persons with Mental Retardation.

Applications may be developed by community providers or by 310 agencies, but they must be submitted through the 310 agencies to the DMH/MR regional community service (RCS) offices, of which there are five. A QMRP in the RCS office will review the results of all test or assessment information provided with the application and determine the eligibility of all individuals seeking waiver services. The QMRP in the RCS office is comparable to the QMRP who performs the initial level of care evaluation for applications to ICF/MR facilities in Alabama.

The RCS office, once an application is approved, submits information electronically to the Medicaid fiscal intermediary to register the person in the long-term care system as a recipient of MR Waiver services. The Alabama Medicaid Agency reviews a ten percent(10%)sample of eligibility determinations and redeterminations.

The information required by the RCS office is a standard application packet plus specific additional assessments. The basic application packet consists of a Level of Care Evaluation, a Plan of Care, a Summary of Habilitation form, and a Dissatisfaction of Services form to notify the applicant of his or her right to due process. The plan of care incorporates the consumer’s statements of choice. Additional forms are required if the applicant is not already Medicaid eligible and is applying for a special income level or waiver of deeming.

Initial applications must also include:

a. Information from a psychological assessment which has been administered after age 17 for adults and within three years of the application date for children and youth below 20 years of age. A copy of the psychological evaluation, performed by a qualified professional and reflecting a score of two or more standard deviations below the norm for the instrument used must be retained on file by the submitting agency and submitted if requested by the RCS office.
b. Information to prove the individual had mental retardation prior to age 18 is required, but ordinarily will be self evident from school records and other collateral assessments. However, with individuals of middle age and above, who may not have attended school, an effort must be made to rule out other, non-developmental causation, such as head trauma subsequent to age 18.
c. Information from a standardized measurement of adaptive behavior that has been administered within 90 days prior to application. The ICAP (Inventory for Client and Agency Planning, Riverside Publishing Co.) is required, but it may be augmented by other instruments such as the ABS or Vineland. The results must support the conclusion that the individual has significant deficits in adaptive behavior. If the person is already on the waiting list, the ICAP information previously reported will be valid for two

years, and beyond two years if the case manager verifies the basis of the information previously submitted has not changed.

d. A copy of a physical examination form signed by a physician, or a summary of a physical assessment performed by a registered nurse conducted within 365 days prior to the application, describing the medical status of the individual must be retained on file by the submitting agency and submitted if requested by the RCS office.
e. A social developmental summary completed or updated within 90 days prior to application describing family structure, routine and goals, developmental history and social and environmental factors affecting the individual's need for services, must be submitted. This summary must be developed and/or approved by a QMRP.

Annual re-determinations must include, along with the basic package:

a. Written reference to and update of the original psychological evaluation which documented the applicant's mental retardation or of a more recent full assessment, all documents to be kept on file and produced if requested.
b. An update of the adaptive behavior evaluation that was administered within the previous 24 months. ICAPs will not need to be re-administered if nothing about the functioning level has changed.
c. An annual medical report must be on file.
d. A social summary updated within 90 days of re-determination.

Current collateral assessment information may be gathered and used from other organizations familiar with the individual seeking services (e.g., schools).

If the test/assessment information is not complete or is inconclusive regarding the type or level of disabilities of the individual, the RCS office QMRP may request additional tests/assessments. The RCS office will make the determination of eligibility and notify the referring organizations or party within five working days from receipt of request for services. If additional testing/assessment is needed to make a determination of level of care, the QMRP will notify the referring organization or party, also within five working days of receipt. This action will stop the level of care determination process until the additional information has been received.

If the QMRP in the RCS office determines that an applicant is ineligible for MR Waiver services, he or she provides written notification to the applicant or applicant's family member, with a copy to the referring organization or party and a copy to the Alabama Medicaid Agency. The written notice includes notice of the right to appeal. Appeals regarding the determination of level of care are conducted by DMH/MR on behalf of the Alabama Medicaid Agency using appeals procedures approved by the Alabama Medicaid Agency. These procedures include notification to the person and/or his representative that in addition to the DMH/MR appeals process, they may request a fair hearing from the Medicaid Agency.

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

_____ Every 3 months

_____ Every 6 months

__X__ Every 12 months

_____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

__X__ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_____ "Tickler" file

__X__ Edits in computer system

__X__ Component part of case management

_____ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

_____ By the Medicaid agency in its central office

_____ By the Medicaid agency in district/local offices

__X__ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

__X__ By the case managers

_____ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

__X__ By service providers

_____ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. **Two forms are included as an attachment to Appendix D3: the ICF/MR Level of Care Evaluation and the Summary Program of Habilitation.**

The assessment information from which the ICF/MR Level of Care Evaluation is completed is derived from two sources. The Full Scale IQ Score comes from a psychological evaluation, and the functional assessment information comes from the ICAP (Inventory for Client and Agency Planning [Copyright 1986 by the Riverside Publishing Company, 8420 Bryn Mawr Avenue, Chicago, IL 60631]).

The ICAP is a proprietary assessment instrument, widely used in State MR and DD systems as the functional assessment for determining waiver eligibility. In addition to this usage, several states, including Alabama, use the ICAP for setting levels of reimbursement rates.

For eligibility determinations, information from the ICAP automated scoring instrument, the Compuscore, is processed through an algorithm to determine whether or not a person functionally meets the ICF/MR level of care as it applies to Alabama’s State Operated Developmental Center. ICAP Domain Scores received by the applicant in specific functional areas Are compared to Domain Scores in the same functional areas scaled specifically for the State of Alabama by the authors of the ICAP, to determine if the identified deficit is significant.

When the individual can be served, the Summary Program of Habilitation, together with the Plan of Care, documents the services the person will need to be supported in the community, and how the services will work to meet the person’s health and welfare needs.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

__X__ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

a. Free choice between Institutional and home and community-based services is documented on the Plan of Care.

b. Following is a description of the procedures by which eligible individuals or their representatives are informed of the feasible alternatives available under the waiver.

As part of assessment and service coordination, consumers and/or responsible parties are provided with adequate information to make an informed decision regarding community based care. This process frequently

includes visits to programs and facilities and meetings with multiple providers in the area. Service coordination addresses problems and presents feasible solutions.

Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

c. Following is a description of the State's procedures for allowing individuals to choose either institutional or home and community-based services

Each person served through the waiver must make a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the plan of care form and has no legal or responsible party who can sign. In such a case, the case manager must document the reason(s) for absence of a signed choice and the efforts made to locate a responsible party who could have signed for the person.

d. Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the administering agency adversely affects his/her eligibility status or receipt of service. The formal process is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code. A Hearing Officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the person's treatment team discuss proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/ representative.

Whenever there is a decision by the administering agency to reduce, suspend, or terminate MR/DD waiver services to coincide with the person's current need, or fitting the service definition, or the person's loss of eligibility for the service, the Department of Mental Health and Mental Retardation (DMH/MR) will issue a written 10 day advance notice to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal. A copy of the notice will be forwarded to the Medicaid Agency, and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E.

Attached is the **Dissatisfaction of Services** form which is presented to each waiver participant and his family/representative as part of the planning process, and which each participant or family/representative must sign, acknowledging receipt of the information regarding his/her right to

a hearing.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The plan of care with all required signatures will be maintained at the Department of Mental Health and Mental Retardation's Regional Community Services Offices.

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

_____ Social Worker (qualifications attached to this Appendix)

__X__ Case Manager

__X__ Other (specify):
Appropriately constituted interdisciplinary team including a QMRP (Qualified Mental Retardation Professional), as defined at [42 CFR 438.430]). A community specialist may serve as the QMRP on the interdisciplinary team.

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

__X__ By case managers

_____ By the agency specified in Appendix A

_____ By consumers

__X__ Other (specify):

By Service Providers

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

_____ Every 12 months

__X__ Other (specify):

Person centered plans are subject to continuous revision. However, at a minimum, the entire team performs a formal review at least annually. The case manager will maintain at least quarterly contact with each individual or their family or guardian. During quarterly contact, the case manager will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring.

It is also the case manager's responsibility to review the provider's notes at least quarterly, and note any problems, discrepancies, dramatic changes or other occurrences that would indicate a need for renewed assessment. The case manager's review of the provider notes will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk.

The Medicaid Agency's Quality Assurance Unit reviews recipient records to ensure the care plans are being reviewed at least every 90 days.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The Medicaid agency will review a sample of 10% of waiver plans of care (and related documents) monthly. This review by staff from the State Medicaid Agency ensures individuals receiving waivered services had a plan of care in effect for the period of time services were provided. They also ensure that the need for services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

APPENDIX F – AUDIT TRAIL VERSION 06-95

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

_____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

_____ Other (Describe in detail):

APPENDIX F

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

   X Yes

   _____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   X All claims are processed through an approved MMIS.

   _____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

_____ The Medicaid agency will make payments directly to providers of waiver services.

X The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

X Providers may ***voluntarily*** reassign their right to direct payments to the following governmental agencies (specify):

The Department of Mental Health and Mental Retardation and community organizations incorporated under Act 310 of the 1967 State Legislature.

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

Waiver claims from these providers will be submitted to the same Medicaid Fiscal Agent used by the rest of the Medicaid programs using unique provider numbers and service indicators for tracking. These claims will be adjudicated and paid by the Medicaid Fiscal Agent.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

Providers participating in the MR Waiver must have a performing provider agreement with The Department of Mental Health and Mental Retardation and be enrolled with The Alabama Medicaid Agency. The agreement with DMH/MR must be in place prior to enrollment with Medicaid and will serve as verification that the provider meets all the qualifications and standards in the approved waiver document. The Medicaid Agency's fiscal agent enrolls providers for the Medicaid agency. Once the enrollment forms are completed and accepted the MR Waiver provider will receive a performing provider number that must be used when billing for MR Waiver services. There are unique procedure codes for services in the MR Waiver.

Once a person's eligibility for participation in the waiver is established, information is added to the MMIS Waiver Long Term Care (WLTC) file. The appropriate eligibility date segment is added to the WLTC file. All claims for waiver services are edited against the WLTC file to make sure the dates of service fall between the effective dates on the WLTC file and that the provider number matches.

Reimbursement for services in the MR Waiver, effective 10/1/03, will be an acuity adjusted based rate system. Note that this represents a change: The MR Waiver has always operated on a cost based reimbursement basis, with each provider having a unique rate for each service, contracted by the DMH/MR. The DMH/MR has worked with a task force of provider representatives to develop standard rates for most services, and a standard rate setting methodology for residential and day habilitation. The methodology adopted for day habilitation established four rates based on standard staffing patterns. The rate for each participant will be determined by that person's ICAP service score, which is derived from an algorithm of adaptive and maladaptive scores.

The methodology adopted for residential habilitation is driven by the staff hours needed by each individual, divided by the number of other individuals sharing those staff hours (staff ratio). A standard rate per hour for direct service staff was developed from surveys. Supervision hours (house managers and QMRPs) are derived by formula from the direct support hours. Additional professional hours can be added to the worksheet as well. Indirect administrative and non-personnel operating costs are based on the direct support costs, and were derived from averages of these cost centers as reported in Medicaid cost reports. In the manner, all costs related to room and board were clearly excluded.

Transition from cost based reimbursement to an acuity adjusted based rate system will require providers to submit cost reports for waiver years ending 9/30/04 through waiver year ending 9/30/06. The rates and rate setting mechanisms have been tested with the entire population of MR Waiver participants, and while some adjustments will need to be made to ensure continued statewide access to the services, the tests proved generally positive.

The DMH/MR will use the new standard rates and rate-setting tools to contract with the providers. The providers will bill the Medicaid fiscal agent their contract rate, using HIPAA compliant transaction codes. Claims submitted electronically are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of those clients who are Medicaid and waiver eligible, and to providers who are enrolled on the date a service was delivered.

Medicaid (EDS) will pay the DMH/MR, which will assure that the unit rate billed by the provider is in fact the contracted rate. The MR Waiver provider will receive payment from DHM/MR as reimbursement for services rendered. An

explanation of payment indicating the disposition of billed services will also be sent to DMH/MR, which will forward it to the provider. Payment for MR Waiver services is payment in full and the individual recipient cannot be billed or held responsible.

Any provider who wants to be paid directly from the Medicaid Fiscal Agent may be set up to do so, understanding that a manual review of each billing will have to be conducted to verify his contracted rate and units, and to assure that state match is paid (this comes from the DMH/MR).

The following documentation will be maintained to establish a clear audit trail: the person-centered plan, the waiver plan of care, a history of authorized and paid services by fiscal year, information collected and maintained by the Medicaid MMIS system including copies of all paid and denied claims, Medicaid explanation of payment information, and eligibility information on each client served.

MR Waiver providers are required to maintain financial records and service documentation on each waiver client including the name of the recipient, the recipient's Medicaid number, the name of the individual provider who delivered the service, the date that the service was rendered, the units of service provided, the place of service, attendance and census data collection, progress notes and monthly summaries. Providers must retain records and other information for a period of three years. These records shall be accessible to the Department of Mental Health and Mental Retardation, the State Medicaid Agency and other appropriate state and federal officials.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	37,892	5,971	137,998	876
2	40,870	6,691	143,380	883
3	42,718	7,411	148,971	890
4	44,408	8,131	154,781	897
5	45,789	8,851	160,818	905

APPENDIX G 1 – COMPOSITE OVERVIEW

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	**5200**
2	**5200**
3	**5260**
4	**5260**
5	**5260**

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

X The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages.

APPENDIX G-2
FACTOR D

LOC:

Demonstration of Factor D estimates:

Waiver Year 1_____ 2_____ 3_____ 4_____ 5_____

Waiver Service	#Undup.Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				
FACTOR D (Divide total by number of recipients):				

AVERAGE LENGTH OF STAY:

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify): **Residential Habilitation**

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify): **N/A**

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

The rate setting methodology for residential habilitation is described in Appenix F, Addendum, on page 74. Indirect costs in the residential rate setting instrument were derived from Medicaid approved cost reports that do not include any room and board. An administrative percentage of 15% was derived as an average ratio of administrative personnel costs to direct service personnel costs. A non-personnel operating cost of $19.25 per day (with $3.50 specifically for basic transportation) was identified as an average of such cost centers on the Medicaid cost reports.

Participants' benefits pay for room and board, with moderate supplementation by the State.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

_____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: **ICF/MR**

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: **ICF/MR**

Factor D' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

X Based on HCFA Form 372 for years **FY'2007 & FY 2009** of waiver # **0001.90.R4.03** , which serves a similar target population.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

APPENDIX G-6

FACTOR G

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_____Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

_____Based on trends shown by HCFA Form 372 for years _____of waiver #_____, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

_____Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

_____Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

___**X**___Other (specify):**Because Alabama has downsized its Developmental Centers over the last four years, and finally closed three of the four centers in fiscal year 2004, the State has rebased its estimate of cost for ICF/MR services. Current year costs for the one remaining Developmental Center and the three small (7 to 9 bed) ICF/MRs in the State were projected and blended using current rates and days of care. The resulting average cost was trended for the five year period of the renewal**

using a 3.9 percent annual inflator. This percent was taken from Bureau of Labor Statistics Consumer Price Index-All Urban Consumers. The Area was South-Size Class A, and the Item was Medical Care. 3.9% was the average 12 month percent change recorded for the last half of 2003, which is the last full year record available.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor

FACTOR G'

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

FACTOR G'

LOC: **ICF/MR**

Factor G' is computed as follows (check one):

_____Based on HCFA Form 2082 (relevant pages attached).

____Based on HCFA Form 372 for years _____of waiver # _____which serves a similar target population.

Note: the average cost from the FY 2005 372 report (the most recent available) was used as a base. This cost was trended forward by 3.4%, which figure was taken from the Bureau of Labor Statistics, Consumer Price Index for August, 2001. The group used was Medical Care in the South Region.

_____Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___**X**___Other (specify): **Because Alabama has downsized Its Developmental Centers over the last four years, and finally closed three of the four centers in fiscal year 2004, the State has rebased its estimate of cost for ICF/MR services. Current year costs for the one remaining Developmental Center and the three small (7 to 9 bed) ICF/MRs in the State were projected and blended using current rates and days of care. The resulting average cost was trended for the five year period of the renewal using a 3.9 percent annual inflator. This percent was taken from Bureau of Labor Statistics Consumer Price Index-All Urban Consumers. The Area was South-Size Class A, and the Item was Medical Care. 3.9% was the average 12 month percent change recorded for the last half of 2003, which is the last full year record available.**

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: **ICF/MR**

YEAR 1

FACTOR D:	**$37,892**		FACTOR G:	**$137,998**
FACTOR D':	**$ 5,971**		FACTOR G':	**$ 876**
TOTAL:	**$43,862**	≤	TOTAL:	**$138,874**

YEAR 2

FACTOR D:	**$40,870**		FACTOR G:	**$143,380**
FACTOR D':	**$ 6,691**		FACTOR G':	**$ 883**
TOTAL:	**$47,561**	≤	TOTAL:	**$144,263**

YEAR 3

FACTOR D:	**$42,718**		FACTOR G:	**$148,971**
FACTOR D':	**$ 7,411**		FACTOR G':	**$ 890**
TOTAL:	**$50,129**	≤	TOTAL:	**$149,862**

YEAR 4

FACTOR D:	**$44,408**		FACTOR G:	**$154,781**
FACTOR D':	**$ 8,131**		FACTOR G':	**$ 897**
TOTAL:	**$52,539**	≤	TOTAL:	**$155,679**

YEAR 5

FACTOR D:	**$45,789**		FACTOR G:	**$160,818**
FACTOR D':	**$ 8,851**		FACTOR G':	**$ 905**
TOTAL:	**$54,640**	≤	TOTAL:	**$161,723**